STATE OF MICHIGAN

DEPARTMENT OF LABOR & ECONOMIC GROWTH

OFFICE OF FINANCIAL AND INSURANCE REGULATION

Before the Commissioner of Financial and Insurance Regulation

In the matter of

XXXXX
Petitioner **File No. 87156-001**
v

Blue Cross and Blue Shield of Michigan
Respondent
_____/

Issued and entered
this 29th day of April 2008
by Ken Ross
Commissioner

ORDER

I
PROCEDURAL BACKGROUND

On January 11, 2008, XXXXX, on behalf of her minor son XXXXX (Petitioner), filed a request for external review with the Commissioner of Financial and Insurance Services under the Patient's Right to Independent Review Act (PRIRA), MCL 550.1901 *et seq*. The Commissioner reviewed the request and accepted it for external review on January 18, 2008.

The Commissioner notified Blue Cross and Blue Shield of Michigan (BCBSM) of the external review and requested the information used in making its adverse determination. The Commissioner received BCBSM's response on February 11, 2008.

The issue in this external review can be decided by a contractual analysis. The contract here is the BCBSM Flexible Blue RX Program Certificate (the certificate). The Commissioner reviews contractual issues pursuant to MCL 550.1911(7). This matter does not require a medical opinion from an independent review organization.

II
FACTUAL BACKGROUND

At all time pertinent to this matter, XXXXX had BCBSM prescription drug coverage through

her employer. Her husband, XXXXX, had United Healthcare drug coverage through his employer. XXXXX's coverage is considered the primary coverage for the Petitioner through application of the Michigan Coordination of Benefits Act, MCL 550.251, *et seq*.

On January 25, 2007, XXXXX, a mail order pharmacy, filled a prescription for the Petitioner. The drug dispensed was Genotropin Miniquick, a growth hormone. The charge for this drug was $10,938.81. A claim was submitted to United Healthcare. In processing the claim, United assumed it was the primary carrier. As noted above, however, the primary carrier was BCBSM and, as primary carrier, BCBSM should have received and processed the claim first. United processed the claim in the following manner:

Amount charged	$10,938.21
Amount approved	$8,641.19
Applied to deductible	$3,874.85
Net	$4,766.34
Payment by United (80% of approved amt. less deductible)	$3,813.07

When BCBSM later received the claim and learned that United had already processed the claim, BCBSM assumed the role of secondary carrier and processed the claim on that basis. According to BCBSM, the amount they owe is $1,471.95:

Approved secondary amount (Approved amount less amount paid by United)	$4,828.12
Deductible	$3,356.17
Payment owed by BCBSM	$1,471.95

The Petitioner's parents were dissatisfied with the amount BCBSM paid for the prescription. They appealed BCBSM's payment amount. BCBSM held a managerial-level conference on November 15, 2007, and issued a final adverse determination dated December 12, 2007.

III
ISSUE

Is BCBSM required to pay an additional amount for the Petitioner's January 25, 2007

prescription?

IV
ANALYSIS

Petitioner's Argument

In her request for external review, Petitioner's mother stated,

> BCBSM has elected to pay this claim as secondary which is an incorrect application of coordination of benefits. The estimated payment as primary would have been $4,685.02. Combined with payment from [United] is still less than the total charge.

Since BCBSM is primary, it should pay the approved amount after applying Petitioner's $3,356.17 deductible. BCBSM processed the claim as the secondary payer and paid only $871.95. BCBSM later acknowledged that it should pay $1,471.95. However, even that amount is too low. BCBSM should be required to pay this claim as primary even thought United also paid its primary amount. The Petitioner's insurance agent says she was told by United that United would have paid the same amount whether it was the primary insurer or the secondary insurer.

BCBSM's Argument

BCBSM says that it does not dispute that the BCBSM coverage is primary and the United coverage is secondary for the Petitioner's claims. It is unclear to BCBSM why United processed the claim as primary or why, after it was informed that it was the secondary carrier, it did not take back its payment and pay the claim in question as secondary.

BCBSM says there is agreement that the approved amount for the Petitioner's January 25, 2007 prescription claim is $8,641.19 and it is correct that United paid $3,813.07. This left a balance of $4,828.12. BCBSM then subtracted Petitioner's deductible of $3,356.17 leaving a balance of $1,471.95. This is the amount BCBSM should pay for this claim. BCBSM acknowledges that it paid only $871.95 and is therefore required to pay an additional $600.00 for this claim.

BCBSM argues that once it pays the additional $600.00 it will have paid the proper amount for the Petitioner's January 25, 2007 claim. BCBSM argues that it cannot reprocess the claim is question as a primary payer until United reprocesses the claim at the secondary payer level.

Commissioner's Review

The Petitioner's parents each have a high-deductible health insurance plan through their respective employers. Both plans include a drug benefit which covers the drug at issue in this case. The issue to be resolved is how much each plan is required to pay and how much Petitioner's parents will have to pay. The order in which benefits are determined is governed by the Coordination of Benefits Act (COB Act). MCL 550.251, et seq. This statute is used to establish which of two insurance plans would have to make the first benefit payment when a dependent is covered under both parents' policies. Insurers are designated as a "primary" or "secondary" insurer. The plan covering the parent whose birth date is earlier in the calendar year is the primary insurer. This "birthday rule" governs the present dispute.

The BCBSM certificate describes how benefits are paid. In Section 4 under Coordination of Benefits it states:

> We will coordinate the benefits payable under this Certificate pursuant to the Coordination of Benefits Act, Public Act of 1984 (starting at MCLA 550.251) to the extent that the services covered under this Certificate are also covered and payable under another group health plan, we will combine our payment with that of the other plan to pay up to the maximum amount we would routinely pay for covered services.

BCBSM should have paid the Petitioner's claim as primary and United should have paid this claim as secondary. Had BCBSM processed the claim as primary it would have subtracted Petitioner's $3,356.17 deductible from the approved amount of $8,641.19 and paid $5,285.02. Petitioner could then have submitted the claim to United for reimbursement of the BCBSM deductible. At the time, Petitioner's United deductible was $3,356.17. That would have resulted in United actually paying $365.52 (80% of $3,813.07 minus $3,356.17).

Regardless of which insurer paid as primary, Petitioner was required to meet each insurer's deductible and pay the balance of the approved amount. Petitioner's deductibles were substantial. At the time of the claim, Petitioner's unmet deductible totaled $7,231.02 ($3,356.17 on the BCBSM policy and $3,874.85 on the United policy). These deductible would have to be met by Petitioner

before any coverage would be provided by the insurers.

Since United paid $3,813.07 toward this claim this amount is properly subtracted from the $5,285.02 paid by BCBSM which leaves a balance of $1,471.95. When this amount is fully paid by BCBSM it will combine with the amount paid by United to fully pay the approved amount for this covered service. This is consistent with the coordination of benefits language in the certificate.

In her appeal, Petitioner's mother has suggested that the insurers should pay the amount ($10,938.21) charged by the provider, XXXXX. However, both BCBSM and United have established an approved amount ($8,641.19) which is only a portion of the XXXX's charged amount. It is a standard practice for insurers to negotiate a discount for drugs and other medical services. XXXX, as a participating provider, has agreed to accept the approved amount as payment in full.

V
ORDER

BCBSM's modified final adverse determination of December 12, 2007, is upheld. BCBSM is required to pay an additional $600.00 for the Petitioner's January 25, 2007 prescription claim. BCBSM shall make this payment within 60 days and shall provide the Commissioner with proof of payment within seven days after payment is made. This is a final decision of an administrative agency. Under MCL 550.1915, any person aggrieved by this Order may seek judicial review no later than sixty days from the date of this Order in the circuit court for the county where the covered person resides or in the Circuit Court of Ingham County. A copy of the petition for judicial review should be sent to the Commissioner of the Office of Financial and Insurance Services, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.